Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

13335

5 - SUMMARIES

[redacted]

D I S C H A R G E S U M A R Y

---------NAME--------- NUMBER SEX AGE ADMIT DISC. MED.RECORD# TYPE ROOM#

[redacted] [redacted] M 38 12/30/98 1/01/99 [redacted] [redacted]

DATE OF BIRTH: [redacted] _____PHYSICIAN_____

PHYSICIAN: [redacted] [redacted]

CONSULTANTS: [redacted], M.D.

DISCHARGE DIAGNOSIS: ACUTE ONSET OF ATRIAL FIBRILLATION CONVERTED MEDICALLY, HYPERTENSION, OBESITY, SINUSITIS

This is a pleasant 38 year old white male known to me who has a history of hypertension, morbid obesity and went to the Urgent Care because he had a fluttery feeling to his heart and he just felt weak, he just felt diaphoretic and they checked his blood pressure and it was fine but he was found to have a heart rate around 200 in acute atrial fibrillation. He had heard about this program to lose weight, some pills so he ordered them over the telephone and we feel that this is probably what set him off in acute atrial fibrillation. The name of the product is Natural Herbs and the name of it Metabolife. It's labeled as a dietary supplement and it's 356 PM, has a number on there and it's also labeled too as an herbal formula to enhance your diet and provide energy, however, it's probably promoted as diet aide to lose weight. Has a combination of many ingredients, does have some smaller doses example of vitamin E, magnesium, zinc and chromium and it also had a lot of other ingredients into it in it also. It is put out Metabolife Industry District. There is a toll free number to call 1-888-356-DIET therefore a couple of ingredients which I would be concerned about would be guarana concentrate and it says C but it has 40 mg of naturally occurring caffeine. It also has ma-huang concentrate, aerel part which had 12 mg of occurring ephedrines which is probably offending agent here but it also has things like bee pollen, ginseng, lecithin, bovine complex, damina leaves, sasparillo, golden seal nettles, gotu-kola, spirulina algae and royal jelly and other ingredients is methocelsilca, crocamellouse sodium and magnesium sterate. The reason I went through all this going to report it to the FDA but any rate it started about 3 days before his symptoms started. He did present in atrial fibrillation. He did tolerate from blood pressure. He felt weak but he didn't have any chest pain or chest tightness. He was admitted to the Intensive Care Unit. Dr. [redacted] saw him in consultation on the same day. He was initially given .5 mg dose of Lanoxin. He was started on a Cardizem drip after initial bolus by Dr. [redacted] and eventually had 2 doses of Corvert which converted him to sinus rhythm and he's basically been in sinus rhythm since but he's had some time rate would go up to about 106. Currently though his telemetry monitor shows a rate of about 90's-106. Blood pressure been doing good. He has not had any chest pain. In fact he's tolerated it quite well.

He's not had any shortness of breath or dyspnea. Chest x-ray did not show any heart failure but what the concern is you know we blame it on this probably the offending agent since nothing else had changed, however, we did go ahead and do a 2-D echocardiogram and Dr. [redacted] said this looked okay. There was nothing unusual here and we did cardiac enzymes which were negative, thyroid profile was negative, blood count was negative, electrolytes were okay so basically dieting and this Metabolife I feel is the offending agent, however, at this point we added to his medications which is Accupril, Cardizem CD every day and Rhythmol 150 mg 3 times a day. Dr. [redacted] feels if everything is all equal he does well probably be on at least 3 months, however, as discussed with [redacted] since he don't like taking medicine kind of sunk a little when I told him to another medicine for a couple of months if he tolerates it well you know and does good negotiate earlier if Dr. [redacted] feels he can get by without it but at this point trying to prevent recurrence. We can't say yes or no if it will ever recur, however, would avoid things like this. I talked to him about dieting. We talked about reasonable diet, don't lose more than 1 or 2 lbs. a week for example but I talked to him about the Sugar Buster diet. We talked to him about that. To me that's a reasonable diet. He can stick with those type foods and can stick with it long term because he won't be hungry he might really do better with this diet and he understands. Blood pressure has been doing relatively good. Hospital course has been otherwise uneventful and he is doing well at this time. We talked to him about things like decongestants and stimulants like caffeine and alcohol. He don't smoke or drink either by the way and I certainly wouldn't use over the counter decongestants either. He does have a history of glaucoma too and he's on eye drops for this. Physical examination at this point his temperature is 98.2, pulse rate 97, respirations 18, blood pressure this morning 145/90, however, yesterday his blood pressure ran anywhere from 147-170, 90-104 but we need to adjust his blood pressure medicine. Hopefully Cardizem CD will be helpful, get on a low sodium diet, get on low calorie diet but he's alert and oriented times 4, no acute distress. Head and neck exam normal cephalic, atraumatic, PERRL, EOMI. Oropharynx is benign. Neck supple. Lungs clear to auscultation without rales, wheeze, rhonchi. Heart regular rate rhythm without any murmur. Abdomen soft, obese, nontender, nondistended. Extremities--no cyanosis, clubbing or edema. Just above his knee on his left medially lower thigh is 2 little red spots. It's been there for quite some time and has pustules on each probably .5 cm and it looks like a little folliculitis to me. He does rub it a lot. It is an area which he tends to probably rub when he sleeps. It looks like folliculitis to me. I recommend kind of guarding against excessive rubbing. Treat him with Duricef 500 mg twice a day for 10 days. If it doesn't resolve we can always biopsy. Neurological is nonfocal. Laboratory--LDH this morning 495, CPK 99 on 12-31-98, GOT 23, CPK before that was 89, LDH 495,GOT 27. Chem 7 on 12-31-98 was sodium 141, potassium 4, chloride 105, CO2 26, BUN 16, creatinine 1, glucose 99, digoxin 0.6, LDH 529, GOT 29, CPK 102. CBC shows 8.6 thousand white blood cell count, normal differential, hemoglobin 13.4, hematocrit 39.2, platelet count 195,000, CPK 27, FTI 3.7 high normal is 4.7 this is normal, T4 10.2 and normal, TSH 4.1 and normal. Admission CBC normal. Admission cardiac enzymes showed CPK 141 and chemistry 12 showed everything to be normal, GOT 49, albumin 3.6, otherwise BUN, creatinine, electrolytes all normal. Chest x-ray on 12-31-98 PA and lateral showed mild

cardiomegaly, no acute pulmonary pathology. EKG this a.m. shows normal sinus rhythm, rate 97, no acute abnormality, QR pattern in lead 3, this wasn't on the previous EKG but he came his EKG showed A-fib with a rapid ventricular response 176. Echocardiogram official report is pending but verbally that's what it was as above. Recommend to stop Metabolite, talk about dieting, avoid stimulants, put him on a low salt diet 1800 calorie diet, recommend Sugar Buster, activity as tolerated. Medication will be Rhythmol 150 mg po tid, Cardizem CD 120 mg every day, Accupril 20 mg bid, Duricef 500 mg po bid time 10 days, Timoptic 0.1% 1 drop both eyes bid and follow up with his ophthalmologist for this. Dr. [redacted] wants to see him in 2 weeks. I recommend he keep this appointment. I'd like to see him if he sees Dr. [redacted], otherwise doing well I'd like to see him in one month, give us a 2 week interval there for both of us for me to follow up with him, blood pressure check in office weekly.

[redacted] M.D.

[redacted]
D 01-01-99
T 01-05-99

COPY

[redacted]

HISTORY & PHYSICAL

---------NAME---------	NUMBER	SEX	AGE	ADMIT	DISC.	MED.RECORD#	TYPE	ROOM#
[redacted]		M	38	12/30/98		[redacted]		

DATE OF BIRTH: [redacted] PHYSICIAN

PHYSICIAN: [redacted]

Very pleasant 38 year old white male known to me. He came in today with acute onset of atrial fibrillation with a heart rate of around 200. He was in his usual state of health, however, he went to use some Metabolite Plus to help him lose some weight. He has a history of obesity, hypertension and history of a heart murmur but he started on this Metabolite Plus. Monday he started noticing his heart beating very irregular and a little fast but he didn't really pay any attention to it. However, today at work he started getting short of breath and developed some weakness from it. He had them check his blood pressure and they blood pressure they got was something like 160/125. He went to the Urgent Care and he was found to be in atrial fibrillation with a fast rate. He had a good blood pressure about 130/90 at the Urgent Care, however, and Dr. [redacted] gave me a call and we admitted him the Urgent Care directly to the hospital. Basically, he denied any chest pain with it. He didn't develop any edema from it. He didn't feel any chest tightness, chest pressure. He didn't break out into a sweat but he did feel weak. He did feel short of breath. His chest x-ray didn't show any evidence of heart failure, however. On admission here his blood pressures really looked pretty good. His blood pressure was about 118/55. He has no history of any heart disease, however. I feel that it is probably the Metabolite that stimulated his heart rate. Basically though he denied anything like fever, chills, sweats. He denies any congestion, no hematuria, dysuria or frequency per say.

PAST MEDICAL HISTORY: Hypertension, glaucoma, sinusitis and he has had UTP surgery. Sleep apnea type syndrome 7/96. He did have a 2-D echocardiogram by Dr. [redacted] and it showed possible mild right ventricular enlargement, otherwise it was pretty much normal.

We did an executive 3 profile on him back in 7/98 and it showed everything to be fine. His thyroid was normal. His profile was normal. He had a total cholesterol of 177, HDL 34, LDL 128 and triglycerides 73. He does have a false positive RPR that is around 1/8 but he has negative FTA-ABS and he was seen at the Health Department because they got the false positive result and worked it up and was considered false positive. Basically though his past history is otherwise benign.

PAST SURGICAL HISTORY: Bone fusion on the right ankle in 1979. He has had a vasectomy.

FAMILY HISTORY: His father had colon cancer around age 55. High blood pressure in his mom, adult onset diabetes.

SOCIAL HISTORY: He doesn't smoke. He does consume alcohol occasionally. He does not do drugs.

MEDICATIONS: Accupril 20 mg bid, Temoptic 0.1% drops 1 drop both eyes everyday. He takes Centrum vitamins everyday. He uses Ambien 10 mg 1/2 to 1 at bedtime as needed for sleep.

REVIEW OF SYSTEMS: Otherwise non-contributory.

PHYSICAL EXAM: Afebrile, vital signs are stable. He is alert and oriented times 4, no acute distress. Head and neck exam: normocephalic, atraumatic, PERRL, EOMI. Oral pharynx is benign. Neck is supple, lungs are clear to auscultation without rales, wheezes or rhonchi. Heart: irregularly irregular, fast rate, however, he has since converted to regular rate and rhythm without any significant murmur. Abdomen is morbidly obese, soft, non-tender, non-distended. Extremities: no cyanosis, clubbing or edema. Neurological exam is non-focal.

LABORATORY WORK: LDH is elevated at 666, high normal is 618. CPK is okay at 141, sodium is 143, potassium 4.3, chloride 107, BUN 17, calcium is 9.1, creatinine 1.1, glucose 101, GOT 29, total protein 6.4, albumin 3.6, alkaline phos 78, total bilirubin 0.6. Chest x-ray: obese, portable, difficult to read. EKG showed fast rate of atrial fib around 176.

He was initially given Lanoxin .25 mg IV which slowed it slightly. He was given a repeat dose 1 hour after that. Dr. [redacted] was consulted and started him on Cardizem drip. After being given 10 mg IV it helped control it but he was given 2 doses of Corvert which ultimately converted to normal sinus rhythm. At this point he is stable. We are going to continue to follow him in the unit tonight and continue the Cardizem drip tonight. We will do a 2-D echocardiogram with doppler. We had a very long discussion with him about the causes or potential causes of atrial fibrillation. At this time I feel it might have been the Metabolite Plus and we are going to need to make an incident report as far as this medication and he is bringing in the medication so we can see what is going on with him. We are going to keep him on his blood pressure medication. We are going to do a thyroid profile on him too and activity bed rest with bathroom privileges for now., Monitor his I&O's, monitor his blood pressure closely.

[redacted]
D 12-30-98

[redacted] MD

[redacted]

CONSULTATION

---------NAME---------	NUMBER	SEX	AGE	ADMIT	DISC.	MED.RECORD#	TYPE	ROOM#
[redacted]	[redacted]	M	38	12/30/98	1/01/99	[redacted]		

DATE OF BIRTH: [redacted] _____PHYSICIAN_____

PHYSICIAN: [redacted] MD [redacted]

DATE OF CONSULT: 12-30-98

Patient 36 year old white male with 2 day history of palpitations. Went to Urgent Care today and found to be in atrial fibrillation rapid ventricular response rates up to 200. Patient recently has started on a diet, some type of diet, medicine Metabolife which is some herbal weight loss recipe for the last 5 days. Patient denies any history of myocardial infarction, heart surgery, pacemaker implantation, rheumatic fever or diabetes. Does have a history of hypotension for 6 years. No history of GI problems or lung problems.

Surgical history--right ankle surgery in 1991, T & A in the past.

No known drug allergies.

Medications include Accupril 20 mg po bid, Lanoxin .125 mg IV given.

SOCIAL HISTORY: Patient works in security. No history of smoking. ETOH none.

FAMILY HISTORY: _____.

REVIEW OF SYSTEMS: Noncontributory.

PHYSICAL EXAM: Pleasant appearing male in no acute distress. Blood pressure 130/84, pulse 165. Neck without JVD. Lungs clear to auscultation. Cor PMI at 5th intercostal space and mid clavicular line, S1 greater than S2, A2 greater than P2 with a 2/6 systolic ejection murmur at lower left sternal border. Abdomen soft, nontender, positive bowel sounds which are normal. Extremities without edema.

ASSESSMENT: EKG ATRIAL FIBRILLATION RAPID VENTRICULAR RESPONSE, ATRIAL FIBRILLATION RAPID VENTRICULAR RESPONSE POSSIBLY SECONDARY TO WEIGHT LOSS MEDICATION, PALPITATIONS TIMES 2 DAYS FELT TO BE NEW ONSET TIMES 2 DAYS, HYPERTENSION TIMES 6 YEARS, WEIGHT 340 LBS.

PLAN: Because of recent onset of atrial fibrillation 2 days consider new onset, will give Corvert IV to convert to sinus rhythm, echo with doppler once

decreased ventricular response, enzymes for myocardial injury, TSH for _____.

[redacted] M.D.

[redacted]
D 12-31-98
T 01-04-99

[redacted]

COPY

[redacted]

D I S C H A R G E S U M M A R Y

---------NAME---------	NUMBER	SEX	AGE	ADMIT	DISC.	MED.RECORD#	TYPE	ROOM#
[redacted]		M	38	2/03/99	2/05/99	[redacted]		[redacted]

DATE OF BIRTH: [redacted] _____PHYSICIAN_____

PHYSICIAN: [redacted]

CONSULTANT: DR. [redacted]

HISTORY AND PHYSICAL: ON CHART

DISCHARGE DIAGNOSIS: ATYPICAL CHEST PAIN
HYPERTENSION
OBESITY
HISTORY OF A FIB, CONVERTED

HOSPITAL COURSE: This is a pleasant 38 year old white male who is known to me. He came in with acute onset of atrial fibrillation in the last admission which was the first episode, and work up was negative. He was converted and he was on Rhythmol and Cardizem as well as Accupril for his blood pressure. He has been on Sugar Buster's diet lately and has lost a couple of pounds. He was at work on the day of admission and felt a little sudden discomfort in his chest and in the left upper chest. It felt like a pressure sensation. It felt like he could not take a deep breath or at least get over a slope with his breathing. He says that it was a very odd feeling and left him weak. It lasted briefly. He had an episode a couple of weeks ago. He came to the Emergency Room and was admitted for observation and evaluation. He has a history of hypertension, but his blood pressure was normal when he came in. Work up included telemetry monitoring in hospital showing only normal sinus rhythm. He had a holter monitor which did not show any malignant arrhythmia and the full report is pending. Dr. [redacted] had looked at it prior to this discharge. He had one leg larger than the other. He felt that this was more of a chronic condition. This raised the concern for a potential DVT and possible pulmonary emboli. He had a duplex venous doppler of the lower extremities done. There were no findings of DVT. A pulmonary ventilation scan was also done. Dr. [redacted] read the study but Dr. [redacted] had read it over the telerad the prior evening. Dr. [redacted] report says that it was a poor ventilation study but had good profusion study. No evidence of pulmonary emboli was noted. Dr. [redacted] looked at it the next morning, and she felt that it was a good ventilation study and the profusion study was also good. There was no evidence of pulmonary emboli at all. It definitely looked good. Carotid duplex study was done showing minimal intimal thickening present. There was no significant plaque in either internal carotid artery system. The left vertebral artery and the right vertebral artery both had forward flow. This study was ok. He had serial EKG's

which did not show any change. The average heart rate on the holter monitor was 78, minimum was 49 occurring at 1:55 a.m. when he was asleep and the maximum was 122 beats occurring at 2:23 a.m. Ventricular ectopy consisted only of eleven single beats and the whole thing only showed four minutes and thirty seconds of a tachycardia. The fastest episode was at 2:32 a.m. lasting 73 beats and averaged about 122 beats a minute. The slowest bradycardia was at 1:55 a.m. lasting eleven beats and averaging 49 beats. SVT ectopy was nineteen beats, 15 with PAC's and four with atrial couplets. Therefore, the report was ok. The longest R to R interval was 1.38 seconds. There was no V tach seen, but he did have some of these episodes described during the monitoring study. He did note that his p.m. dose the night before discharge, after taking his Rhythmol, he noted the sensation. So he is correlating this to the Rhythmol, so we will discontinue this. Hopefully, he will not have return of his atrial fibrillation. This was a single episode and we will keep him on the Cardizem. His blood pressure has been doing well. He would have episodes of breakthrough increased blood pressure. Yesterday, his highest pressure was 156/106 times one but he started the day out at 121/71 and ended that day with 137/81. He had 142/85 at the time of discharge. It would intermittently go up. He had an EKG on 2/4/99 which showed normal sinus rhythm. He has a Q wave type pattern in lead 3, but this is his baseline.

LABORATORY STUDIES: Cardiac enzymes were basically negative. His CPK on 2/4/99 at 19:26 hour was 58. It was 58 before that. His SMA 7 showed sodium of 144, potassium 4.4, chloride 105, CO2 28, BUN 10, creatinine 0.9, glucose 103. TSH was 2.3. PTT was 20.3 with control of 24.3. PT was 12.6 with a control of 12.3. White blood cell count was 7.1 thousand, hemoglobin 15, hematocrit 43.6, platelet count 191,000. Differential was normal. CPK was 68 prior to this one. GOT was 17, LDH 443; initial CPK was 77. Troponin was 0.0. CPK MB was 1.

Chest x-ray showed no acute findings.

At this point, everything is looking good, and he is requesting to go home. Plan is to give him a 24 hour ambulatory holter monitor because of the significance of his symptoms. We did not see any signs of DVT or pulmonary emboli; however, if,this keeps occurring, I think we should try to do something like an arteriogram pulmonary to rule out such an event.

PHYSICAL EXAMINATION: Temperature is 98, heart rate 81, respirations 24, blood pressure 142/85. He is alert and oriented times four in no acute distress. Head and neck exam is normocephalic, atraumatic. PERRL EOMI. Oropharynx: He has past history of UTPP surgery. Otherwise, it is benign. Neck is supple without JVD, mass or bruits. Lungs are clear to auscultation without rales, wheezes or rhonchi. Heart has a regular rate and rhythm without murmur. Abdomen is obese, nontender, nondistended. Extremities: No cyanosis, clubbing, but

there is trace edema chronically. His left leg is larger than the right probably mild to moderately so. Neurological exam is non-focal.

DIET: 1800 calorie diet, low salt

ACTIVITY: Ad lib, 24 hour holter monitor for Dr. [redacted] to read

DISCHARGE MEDICATIONS: Cardizem CD 120 mg. every day, Accupril 20 mg. po bid, ecotrin 5 grain one every day, Timoptic eye drops for glaucoma

I want to see him in two weeks, and Dr. [redacted] wants to see him in two weeks also. I will see him sooner if needed. Call for any problems.

[redacted] M.D.

[redacted]
D 02-05-99
T 02-07-99

[redacted]

HISTORY & PHYSICAL

---------NAME--------- NUMBER SEX AGE ADMIT DISC. MED.RECORD# TYPE ROOM#

[redacted] M 38 2/03/99 [redacted]

DATE OF BIRTH: [redacted] _____PHYSICIAN_____

PHYSICIAN: [redacted] MD [redacted]

He's a 38 year old white male who's known to me. He was last admitted for an acute onset of atrial fibrillation which was converted and he's been on medication Rhythmol for that and Cardizem. His blood pressure's under good control. Says he's actually been feeling pretty good. He's been on Sugar Buster diet. He's lost 2 lbs. of weight and at work today though he was kind of leaning of counter. All of a sudden he felt a discomfort feeling in his chest and in his left upper chest. It feels like a pressure sensation. Also felt like he couldn't take a good deep breath or at least get over a slope. It's a very odd feeling. He found it difficult to describe. It said it lasted briefly. Was associated with some dizziness and he told the girl he was talking to to kind of watch him if he was to fall out call someone because he did felt kind of weak. Basically though he said he felt another episode of this and about a couple of weeks ago he was having blood pressure checked in my office. He said he mentioned something to my nurse at the time. He said it was a brief thing and it never happened again until today and he had even forgot about it. His blood pressure is under good control. He hadn't really had any fever, chills or sweats but he does have a chronic intermittent cough. He said his sinuses feel good. He hadn't had any wheezing or shortness of breath and these episodes are brief and sometimes they are associated with dizziness and he was wondering if it might be related to panic although he's not feeling stressed. He said there's always something going on in his life but he doesn't really feel pressure or stress like one would anticipate so to speak. Nevertheless, he came to the emergency room. EKG was normal. Initial laboratory work was unremarkable and he been admitted for evaluation. Telemetry monitor mostly showed some normal sinus rhythm so far. He does have a little swelling to his lower legs. He's had it before, left greater than right but there hasn't been any tenderness in the calf but his left leg is definitely a little larger than his right. He hasn't any history of any blood clots, however. Certainly pulmonary emboli would have to be a potential consideration.

Past medical history is positive for hypertension, one episode of atrial fibrillation converted, obesity, sinusitis. No history of MI, no history of stroke. There is a family history of hypertension, diabetes, cancer and strokes, see old record. He does have glaucoma. He's on Timoptic eye drops, baby aspirin every day.

Socially he does not use alcohol. He does not smoke. He doesn't do any drugs of abuse.

Surgical history included T & A and some sinus surgery. He had a UTPP surgery for sleep apnea. Drug allergies is to IVP dye. Medications are Accupril 20 mg bid, Cardizem CD 120 mg every day, Rhythmol 150 mg tid.

Review of systems is otherwise unremarkable.

PHYSICAL EXAMINATION: Weight 354 lbs. Blood pressure 139/87, pulse rate 82, respiration 20, temperature 97.3. Alert and oriented times 4, no acute distress. Head and neck exam normal cephalic, atraumatic, PERRL, EOMI. Oropharynx is basically benign. Neck supple without any JVD, mass, bruit. Lungs clear to auscultation without rales, wheeze or rhonchi. Heart regular rate rhythm, distant heart sounds but no definite murmur. Abdomen obese, soft, nontender. Extremities--his left leg is larger than his right. He does have some mild trace edema of his left leg. Can't palpate any specific tenderness and there is no obvious erythema. Neurological exam is nonfocal.

CBC shows 7.4 thousand white blood cell count, hemoglobin 15, hematocrit 43.9, platelet count 204,000, differential is normal. SMA-7 shows glucose 90, sodium 143, potassium 4.3, chloride 106, CO2 27, BUN 13, creatinine 0.7, CPK 99, GOT 17, LDH 511. Chest x-ray report not on chart. 12 lead EKG shows basic normal sinus rhythm, rate 94 and otherwise pretty much unremarkable EKG.

IMPRESSION: EPISODES OF ACUTE BRIEF SHORTNESS OF BREATH AS WE DESCRIBED ABOVE.

PLAN: Dr. [redacted] wants to do a tilt study on him, Holter monitor has been started and he's on a telemetry monitor, monitor his vital signs closely, do a duplex venous doppler of the lower extremities and do a pulmonary VQ scan rule out pulmonary emboli, continue on blood pressure medication at home, continue on eye drops at home and observation and he's to notify us of any chest pain.

[redacted] M.D.

[redacted]
D 02-03-99
T 02-04-99

COPY

[redacted]

CONSULTATION

NAME	NUMBER	SEX	AGE	ADMIT	DISC.	MED.RECORD#	TYPE	ROOM#
[redacted]		M	38	2/03/99		[redacted]		

DATE OF BIRTH: [redacted]
PHYSICIAN: [redacted] MD

PHYSICIAN [redacted]

DATE OF CONSULT: 2-3-99

CONSULTING PHYSICIAN: [redacted], MD

The patient is a 38 year old male who states that for the past month he has had episodes of dizziness and chest fullness lasting seconds when sitting, followed by dizziness. Multiple episodes. The patient was admitted to [redacted] on 12/98 with atrial fibrillation, rapid ventricular response, converted with Corvert. The patient states that his _____ different than at the previous time. The patient denies any history of myocardial infarction, heart surgery, pacemaker implantation, rheumatic fever, diabetes. He does have a history of hypertension times 6 years. No history of GI problems or lung problems.

PAST SURGICAL HISTORY: Right ankle surgery in 1991. T&A in the past.

ALLERGIES: No known drug allergies.

MEDICATIONS: Cardizem CD 150 mg po q day. Accupril _____ mg po bid, Rhythmol _____ mg po tid. Ecotrin 1 po q day.

SOCIAL HISTORY: The patient works in security. No history of smoking. ETOH none.

FAMILY HISTORY: Non-contributory.

REVIEW OF SYSTEMS: Non-contributory

PHYSICAL EXAM: Pleasant appearing male in no acute distress. Blood pressure 139/83, pulse 96, temperature 97.7. Pupils are equal and reactive to light and accommodation. Neck supple. Carotids 2+ bilaterally without bruits. Normal carotid upstroke. No JVD. Lungs clear to auscultation. Cor PMI 5th intercostal space and midclavicular line. S1 greater than S2. A2 greater than P2. 1:2/6 systolic ejection murmur heard over the left lower sternal border. Abdomen soft, non-tender, positive bowel sounds which are normal. Extremities without edema.

EKG sinus rhythm, non-specific ST changes.

ASSESSMENT:
EPISODE OF DIZZINESS AND CHEST FULLNESS LASTING SECONDS. ECHO WITH DOPPLER DONE 1/98: EF OF 50%. THALLIUM 1/98 EXERCISED 6 MINUTES 17 SECONDS, 86% OF MAXIMUM PREDICTED HEART RATE. NO FOCAL ISCHEMIA. HYPERTENSION TIMES 6 YEARS. HISTORY OF ATRIAL FIBRILLATION, INCREASED VENTRICULAR RESPONSE IN 12/98. ON RHYTHMOL.

PLAN: Enzymes for myocardial injury. Holter monitor for evaluation of arrhythmia. TSH _____ patient. Monitor on telemetry. Serial EKG's. Tilt test in a.m. for evaluation of possible neurocardiac axis. Carotid doppler for evaluation of carotid vascular disease. Orthostatic blood pressures. Will follow along with you.

[redacted]
D 2-3-99
T 2-4-99

[redacted] MD

[redacted]